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Reservoir High School
Music Department Annual Spring Trip
Medication Form

USE THIS FORM FOR ALL MEDICATIONS (prescription or over-the-counter)

Student Last Name: _____ First: _____

Date of Birth: Grade:

Physician Name: _____

Address: _____

City/State/ZIP: _____, MD

Phone:

Enter ALL medications whether prescription (Rx) or over-the-counter (OTC). Use key below for entries.

Medication	Rx or OTC	Dose	Frequency	Route	Indication(s) also "X" if As Needed
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Medication: note name and whether prescription (Rx) or over-the-counter (OTC).

Dose should be with units such as 500 mg or 30 ml rather than "Take 1"

Frequency should be listed as "every 8 hours" or "once in the morning". Do not use abbreviations such as "q8h" or "qAM".

Route: spell out, such as orally, topically, injection

FOR OTC MEDICATIONS "ACCORDING TO LABEL" is perfectly acceptable.

Indications: note for what symptoms the medication is to be given - headache, pain, stomach ache, mild allergic reaction, ADHD, low blood sugar, etc.

Physician Signature: _____

Date:

Parent Signature: _____

Date:

Emergency Phone:

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